12-011.08H Initial Rates for New Providers: Providers entering the NMAP as a result of a change of ownership shall receive the rate of the seller for the Direct Nursing, Direct Support Services, Other Support Services, and Inflation Factor Components. The Fixed Cost Component shall be controlled by provisions of 471 NAC 12-011.06E Leased Facilities, 471 NAC 12-011.06G Interest Expense, 471 NAC 12-011.06H Recognition of Fixed Cost Basis, and 471 NAC 12-011.09 Depreciation.

Providers entering the NMAP for a reason other than a change of ownership shall receive, rates determined from the average base rate components of all providers of the same Care Classification, plus the adjusted Inflation Factor, at the time of entering. Provider shall comply with provisions of 471 NAC 12-011.10, Reporting Requirements and Record Retention.

12-011.08J Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.10, Reporting Requirement and Record Retention.

12-011.08K Provisions for Governmental Facilities - City and County Owned Nursing Facility Proportionate Share Pool: A proportionate share pool is created to increase reimbursement to city and county owned facilities. City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility. The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology shall adjust for pharmacy, laboratory, radiology, retroactive payment adjustments, and any other factors necessary to equate Medicaid to Medicare payment methodologies.

The Department shall annually submit to HCFA workpapers demonstrating the calculation of the proportionate share pool, and that calculations have not resulted in payments in excess of the amount which could reasonably be paid under Medicare payment principles.

The pool for each Report Period is calculated and distributed on or about October 1 of that Report Period. Each facility's distribution amount is based on its estimated proportionate share of the pool.

The initial proportionate share pool is created beginning January 1, 1998. Because this is the midpoint of the July 1, 1997 through June 30, 1998, Reporting Period, the pool is prorated to one half. The date for the estimated distribution for this initial prorated period will be on or about April 1, 1998.

Participation in this pool requires each facility to return their proportionate share of the pool, less a participation fee, to the State the same day as received. Each facility retains a minimum participation fee of $10,000 for facility use. In cases where a facility's proportionate share of the pool is less than $10,000, the facility shall receive $10,000.

City and County owned facilities may retain as a participation fee, the greater of:

1. $10,000; or
2. For facilities with a 40% or more Medicaid mix of inpatient days, the current NMAP Federal Financial Participation percentage multiplied by the facility's allowable costs above the respective maximum for the Direct Nursing and the Direct Support Services Components. (This amount is computed after desk audit and determination of final rates for a Report Period.)

12-011.08L Facility Closures: For services provided on or after July 1, 1994, when a facility closes under the following circumstances:

1. Event(s) have precipitated the movement of all residents from the facility within a period of time not to exceed 45 days (the closeout period); and
2. The facility is not certified to provide NF services for a minimum of 30 days after the final resident leaves; and
3. Cost inefficiencies result in the facility costs being over their current prospective rates, then payment is made as follows:
   a. Reasonable and necessary costs which are incurred during the closeout period (the time period from the date of movement of the first resident through the final resident) will be allowed. "Unusual" costs (for example, excessive use of pool labor because permanent employees have left) must be submitted to the Department for approval;
   b. A final cost report for the period of July 1 through the end of the closeout period must be filed in accordance with 471 NAC 12-011.10. Schedules detailing the actual "unusual" costs incurred per a. above, and the actual daily census for the closeout period must also be submitted. Two final rates shall be computed:

      (1) For the closeout period - the identified "unusual" closeout cost and the prorated portion of total period costs shall constitute the total closeout period costs. Actual inpatient days for the closeout period are used to compute the per diem. Rates are not subject to the Direct Nursing, Direct Support Services, or Other Support Services maximums. The Administration expense limitation in 471 NAC 12-011.06N is waived, along with occupancy limitations in 471 NAC 12-011.06B;
      (2) For the period prior to the closeout period - the rate shall be computed from the remainder costs/census in accordance with rates computed through provisions of 471 NAC 12-011.08D through 12-011.08D4;
      (3) The Department shall retroactively adjust interim rates paid to the allowable rates computed per (1) and (2) above.

12-011.09 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreements (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the nursing facility shall use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 1998 edition, to determine the useful life span. In the event that the nursing facility determines a useful life shorter than a life shown in the tables, the facility shall have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 12-011.06H and J.

12-011.09A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

12-011.09B Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be -

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines;
3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 12-011.06H and J);
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

12-011.09C Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

Variable for Classification	Basic Cost Bases Under 40 Beds	Variable for For 40 to 75 Beds	Over 75 Beds
Moveable furniture	$1,000 per bed	$1,000 per bed	$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	$20,000	"
Heating equipment	"	$10,000	"
Air Cond. equipment	"	$10,000	"

12-011.09D Recapture of Depreciation: Depreciation in 471 NAC 12-011.08D refers to real property only. A nursing facility which converts all nursing facility beds to assisted living beds is not subject to recapture provisions. A long term care facility which is sold for a profit and has received NMAP payments for depreciation, shall refund to the Department the lower of -

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times \text{Sales Price - Book Value}$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

Examples:		Data
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4-2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

12-011.09E Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

12-011.09F Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

12-011.10 Reporting Requirements and Record Retention: Providers shall submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation shall prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct/reduce/eliminate data. Providers are notified of changes.

Each facility shall complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 15 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department shall suspend payment. At the time the suspension is imposed, the Department shall send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider shall maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All prospective rate payments made during the rate period to which the cost report applies;
2. All prospective rate payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets shall be retained for a minimum of five years after the assets are no longer in use by the provider. The Department shall retain all cost reports for at least five years after receipt from the provider.

Facilities which provide any services other than certified nursing facility services shall report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility shall not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

12-011.10A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Social Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the nursing facility name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Central Office; pick up copies at the Department's Central Office; or mail copies). The total fee, $5.00 handling for each report requested and an additional $5.00 for each report to be copied and an additional $2.50 for each report to be mailed, must accompany the request. The nursing facility will receive a copy of a request to inspect its cost report.

12-011.11 Audits: The Department shall perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Prospective rates and care classification maximums are determined after the initial desk audit is completed. Subsequent desk and field audits will not result in a revision of care classification maximums.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider shall deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department but must be sufficiently comprehensive to ascertain that the cost report complies with the provisions of this section. The provider shall deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit -

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 12-011.15 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 12-011.15 #2 or when grounds exist to suspect that fraud or abuse has occurred.

12-011.12 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department shall determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. The facility will be notified of the settlement on an MC-7, "Explanation of Medical Claims Activity." Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. (See 471 NAC 12-011.16 for an exception to the 45-day repayment period.) Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. The Department may adjust the interim rate for payments made after the audit completion.

The Department shall determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department shall immediately begin recovery from future facility payments until the amount due is fully recovered.

The Department shall report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

12-011.13 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

12-011.14 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

12-011.15 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director to reexamine or question the correctness of a determination or decision which is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

12-011.16 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days prior to any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

31-008 Payment for ICF/MR Services

31-008.01 Purpose: This section -

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/MR services;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state, and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and

31-008.02 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as July 1, 2000) are used in determining the cost for Nebraska ICF/MRs with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety. That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. Because Title XVIII principles of reimbursement are further restricted by these regulations, the aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

31-008.03 Allowable Costs: The following items are allowable costs under NMAP.

31-008.03A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to -

1. Meet the definition in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

1. Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services and active treatment program as required by certification standards; minor medical supplies; oxygen; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are –
   a. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
   b. Active treatment: The facility shall provide a continuous active treatment program as determined necessary by each client's Interdisciplinary team, including physical therapy, occupational therapy, speech therapy, recreational therapy, and pre-vocational services as described in each client's Individual Plan of Care (see 42 CFR 483.440 and 471 NAC 31-001.02);
   c. Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins, bedpans, etc.;
   d. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, Band Aids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, T.E.D. (anti-embolism) stockings, hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;
   e. Items which are used by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;
   f. Special dietary supplements used for tube feeding or oral feeding, such as an elemental high nitrogen diet, even if written as a prescription item by a physician. These supplements have been classified by the Food and Drug Administration as a food rather than a drug;
   g. Laundry services, including personal clothing; and
   h. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.

2. Injections: The resident's physician shall prescribe all injections. Payment is not authorized for the administration of injections, since giving injections is considered a part of routine nursing care and covered by the long term care facility's reimbursement. Payment is authorized to the drug provider for drugs used in approved injections. Syringes and needles are necessary medical supplies and are included in the per diem rate.

3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility shall provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-008.03C Ancillary Services: Ancillary services are those services which are either provided by or purchased by an ICF/MR and are not properly classified as "routine services." The ICF/MR shall contract for ancillary services not readily available in the ICF/MR.

If ancillary services are provided by a licensed provider, e.g., physician, dentist, etc., the provider shall submit a separate claim for each client served.

Occupational therapy, physical therapy, speech pathology, audiology, psychological, and resident transportation services are considered routine operating costs for ICF/MRs.

Department-required independent QMRP assessments are considered ancillary services.

31-008.03D Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility or ICF/MR providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs*, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000). *Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;

3. Wheelchairs are considered necessary equipment in an ICF/MR to provide care. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use may be approved (see 471 NAC 7-000);
4. Air fluidized bed units and low air loss bed units (see 471 NAC 7-000);
5. Augmentative communication devices/accessories (see 471 NAC 7-000);
6. Supports (elastic stockings, trusses, etc.) as defined in 471 NAC 7-000 excluding surgical/anti-embolism stockings;
7. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
8. Prostheses (breast, eye, lower and upper limb) as defined in 471 NAC 7-000;
9. Oxygen and oxygen equipment, if the client's prescribed need for oxygen meets the minimum liters per minute (LPM) and hours per day as outlined below:

LPM	Minimum Hours Per Day
1.5	24
2	14
2.5	12
3	10
3.5	9
4	8
4.5	7
5	6

10. Repair of medically necessary, client-owned durable medical equipment otherwise covered for clients residing ICF/MRs;
11. Parenteral nutrition solution and additives;
12. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4-000.
    a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP shall not make payment for ambulance service.

b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the Nursing Facility and/or ICF/MR).

31-008.04 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15;
5. Travel and entertainment, other than for professional meetings and direct operations of the facility. Costs of motor homes, boats, and other recreational vehicles including operation and maintenance are not allowable expenses;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state-operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients that are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts. Recreational and therapeutic facilities necessary for the needs of the mentally retarded in ICF/MR's will be allowed.

31-008.05 Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/MRs that are not State-operated.

31-008.05A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.